Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 2/24/2010 9:41
FORM APPROVED
OMB NO. 0938-0050

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).
FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE
THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
(42 USC 1395g).

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1315	PERIOD FROM 10/ 1/2008 TO 9/30/2009	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 2/24/2010 TIME 9:41

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
BCC DBA ILLINI COMMUNITY HOSPITAL 14-1315
FOR THE COST REPORTING PERIOD BEGINNING 10/ 1/2008 AND ENDING 9/30/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 2/24/2010 TIME 9:41

ZjjnQFjcJSqhSsJZ5TYsgGWABzmHa0
dBQICO5DFlfzU0XcxPdSMOnzqr.mSQ
sT7vOEr9EwOoTAg6

PI ENCRYPTION INFORMATION
DATE: 2/24/2010 TIME 9:41

5NJ57qOAKk2JK1FPoTOjM1.BoRmQe0
YjXabOpYecP1ByZFlw.:9GQLNb6iAN
Xi4U38J2WdO1Qlrq

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX
			A	B	
		1	2	3	4
1	HOSPITAL	0	220,885	-1,098,355	0
3	SWING BED - SNF	0	50,202	0	0
9	RHC	0	0	13,593	0
100	TOTAL	0	271,087	-1,084,762	0

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

Blessing Care Corporation
d/b/a Illini Community Hospital
Protested item
September 30, 2009

We believe that the Illinois Provider Tax is an allowable cost under Medicare cost reimbursement principles. We understand that National Government Services does not share this view. The expense is therefore included as a protested item. The reimbursement effect of including this $117,660 of provider tax is to increase reimbursement by approximately $60,000.

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).
FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE
THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
(42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1315	PERIOD FROM 10/ 1/2008 TO 9/30/2009	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 2/24/2010 TIME 9:17

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
BCC DBA ILLINI COMMUNITY HOSPITAL 14-1315
FOR THE COST REPORTING PERIOD BEGINNING 10/ 1/2008 AND ENDING 9/30/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
		1	A 2	B 3	4	
1	HOSPITAL	0	240,900	-1,064,995	0	Difference
3	SWING BED - SNF	0	55,511	0	0	
9	RHC	0	0	14,898	0	59,989
100	TOTAL	0	296,411	-1,050,097	0	
				<753,686>		

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER	B	-34,151	INTEREST EXPENSE	88	
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES					
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-887,371			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1	-460,472			
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-2,417	DIETARY	11	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-6,813	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37	MISCELLANEOUS INCOME	B	-7,029	ADMINISTRATIVE & GENERAL	6	
38	MISCELLANEOUS SUPPLIES REVENUE	B	-2,174	MEDICAL SUPPLIES CHARGED	55	
39	PHYSICIAN RECRUITMENT	A	-425	ADMINISTRATIVE & GENERAL	6	
40	CABLE TELEVISION	A	-1,690	MAINTENANCE & REPAIRS	7	
41	MISCELLANEOUS EXPENSE	A	-17,435	ADMINISTRATIVE & GENERAL	6	
42	PUBLIC RELATIONS SALARIES	A	-19,525	ADMINISTRATIVE & GENERAL	6	
43	PUBLIC RELATIONS EMPLOYEE BENEFITS	A	-5,545	EMPLOYEE BENEFITS	5	
44	PUBLIC RELATIONS EXPENSES	A	-81,066	ADMINISTRATIVE & GENERAL	6	
45	COFFEE SHOP RECEIPTS	B	-44,149	DIETARY	11	
46	MEALS ON WHEELS	B	-7,203	DIETARY	11	
47	LOBBYING EXPENSE	A	-8,708	ADMINISTRATIVE & GENERAL	6	
48	MISCELLANOUS	B	-775	ADMINISTRATIVE & GENERAL	6	
49	NON-RHC PHYSICIAN COST	A	-34,667	RURAL HEALTH CLINIC	63.50	
49.01	PROVIDER TAX	A	117,660	ADMINISTRATIVE & GENERAL	6	
50	TOTAL (SUM OF LINES 1 THRU 49)		-1,503,955			

(1) Description - all chapter references in this columnpertain to CMS Pub. 15-I.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7

HEALTHCARE AND FAMILY SERVICES
HOSPITAL PROVIDER ASSESSMENT PROGRAM
ASSESSMENT CALCULATION AND REMITTANCE
FISCAL YEAR 2010

Current Record	Address Correction
Tax ID: 16009 PIN: 3507	
ILLINI COMMUNITY HOSPITAL 640 WEST WASHINGTON PITTSFIELD, IL 62363	*E-mail Address:*

FISCAL YEAR 2010 ASSESSMENT CALCULATION

37-11-97898- 1131-1130-98

Assessment Period: SEPTEMBER 2009

Assessment base:	**Occupied Beds:**	2,927
	minus Medicare Occupied Beds:	- 2,496
	Total Taxable Beds:	431
	Tax rate:	**X $218.38**
	***Annual Assessment:**	$94,122
	***Monthly Assessment:**	$7,844

* Amounts rounded to the nearest dollar

Rec'd 9-11-09

34645.50
2777.38

HFS

IHFG - dept (537.00

Monthly (A) 7844
* 15
117,660

July 2008 to Sept 2009

State fiscal year 2009 plan not approved until after 10/1/08.

HEALTHCARE AND FAMILY SERVICES *FUND 346*
DIVISION OF MEDICAL PROGRAMS

TO ENSURE PROPER CREDITING OF YOUR ACCOUNT, RETURN THIS CARD WITH YOUR FISCAL YEAR 2010 PAYMENT (September 2009)

ILLINI COMMUNITY HOSPITAL
640 WEST WASHINGTON
PITTSFIELD, IL 62363

Amount Due: $7,844

pd 9-15-09 via E-check on internet 12:30pm

Tax ID: 16009 **PIN:** 3507

Due Date: September 21, 2009

MAKE CHECK PAYABLE TO:
HEALTHCARE AND FAMILY SERVICES

REMIT TO: HFS/BUREAU OF FISCAL OPERATIONS
P.O. BOX 19491
SPRINGFIELD, ILLINOIS 62794-9491

Failure to make payment by the designated due date may result in a 5 percent monthly penalty.

HFS 3752 (R-12-05) Fiscal Year 2010 IL478-248

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96 (07/2009)

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER NO: 14-1315 | PERIOD: FROM 10/ 1/2008 TO 9/30/2009 | PREPARED 2/24/2010 | WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

STREET: 640 WEST WASHINGTON P.O. BOX:

CITY: PITTSFIELD STATE: IL ZIP CODE: 62363- COUNTY: PIKE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

	COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
	0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	BCC DBA ILLINI COMMUNITY HOSPITAL	14-1315		9/ 1/2001	N	O	N
04.00	SWING BED - SNF	BCC DBA ILLINI COMM HOSP-SWINGBED	14-Z315		9/ 1/2001	N	O	N
14.00	HOSPITAL-BASED RHC	BCC DBA ILLINI COMM HOSP-RHC	14-3482		7/ 3/2006	N	O	N

17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 10/ 1/2008	TO: 9/30/2009		
				1	2
18	TYPE OF CONTROL			2	

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	1
20	SUBPROVIDER	

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.			
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106?			
21.02	HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).			
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2	Y	14
21.04	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2		
21.05	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2		
21.06	DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO.	N		
21.07	DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)	N		
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	N		
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.	N		
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /	/ /
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /	/ /
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /	/ /
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /	/ /
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.		/ /	/ /
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /	/ /
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /	/ /
24	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY)			/ /
24.01	IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy).			/ /
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N		
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?			
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.			
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.			
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			

25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)	
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING:	/ /
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING:	/ /
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y 9/ 1/2001
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02	
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	

	1	2	3	4
	0	0.0000	0.0000	
	0.00	0		

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

		%	Y/N
28.03	STAFFING	0.00%	
28.04	RECRUITMENT	0.00%	
28.05	RETENTION	0.00%	
28.06	TRAINING	0.00%	
28.07		0.00%	
28.08		0.00%	
28.09		0.00%	
28.10		0.00%	
28.11		0.00%	
28.12		0.00%	
28.13		0.00%	
28.14		0.00%	
28.15		0.00%	
28.16		0.00%	
28.17		0.00%	
28.18		0.00%	
28.19		0.00%	
28.20		0.00%	

29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	Y
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	Y
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N

MISCELLANEOUS COST REPORT INFORMATION

32	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.	N
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2	N
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?	N
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N
35.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N
35.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N
35.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N
35.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N

		V	XVIII	XIX
		1	2	3
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE			

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

	WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N
	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
.1	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?			

TITLE XIX INPATIENT SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	Y	
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	N	
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	N	
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	N	
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	N	

40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE NUMBER. (SEE INSTRUCTIONS).	Y	14H132
40.01	NAME: BLESSING CORPORATE SERVICES FI/CONTRACTOR NAME NATIONAL GOVERNMENT SERVICES		FI/CONTRACTOR # 00131
40.02	STREET: BROADWAY AT 11TH STREET P.O. BOX: 7005		
40.03	CITY: QUINCY STATE: IL ZIP CODE: 62301-		
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	Y	
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?	N	
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	N	00/00/0000
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).		

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

		PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
		1	2	3	4	5
47.00	HOSPITAL	N	N	N	N	N

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)	N	
.1	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV	N	
53	IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
53.01	MDH PERIOD: BEGINNING: / / ENDING: / /		
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		
	PREMIUMS:	151,056	
	PAID LOSSES:	0	
	AND/OR SELF INSURANCE:	0	
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.	N	

		DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEES 4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01	ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02	THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03	FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?	N	
58	ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.	N	
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).		
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)	N	
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)	N	

1 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(C)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC). — 0

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? ENTER "Y" FOR YES AND "N" FOR NO. — N

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00
62.01						0.00
62.02						0.00
62.03						0.00
62.04						0.00
62.05						0.00
62.06						0.00
62.07						0.00
62.08						0.00
62.09						0.00

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). — Y — 1/31/2010

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96 (04/2005)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | PROVIDER NO: 14-1315 | PERIOD: FROM 10/ 1/2008 TO 9/30/2009 | PREPARED 2/24/2010 | WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS: TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01	TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	25	9,125	48,384.00		1,595		134
2	HMO					19		
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					500		
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	25	9,125	48,384.00		2,095		134
12	TOTAL	25	9,125	48,384.00		2,095		134
13	RPCH VISITS							
24	RURAL HEALTH CLINIC					1,698		
25	TOTAL	25						
26	OBSERVATION BED DAYS							19
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

	COMPONENT	I/P DAYS / TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	TRIPS: TOTAL OBSERVATION BEDS ADMITTED 6.01	TRIPS: TOTAL OBSERVATION BEDS NOT ADMITTED 6.02	INTERNS & RES. FTES: TOTAL 7	INTERNS & RES. FTES: LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			1,997				
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			500				
4	ADULTS & PED-SB NF			45				
5	TOTAL ADULTS AND PEDS			2,542				
12	TOTAL			2,542				
13	RPCH VISITS							
24	RURAL HEALTH CLINIC			7,653				
25	TOTAL							
26	OBSERVATION BED DAYS		19	209	12	197		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS			19				
28	01 EMP DISCOUNT DAYS -IRF							

	COMPONENT	I & R FTES NET 9	FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	FULL TIME EQUIV NONPAID WORKERS 11	DISCHARGES TITLE V 12	DISCHARGES TITLE XVIII 13	DISCHARGES TITLE XIX 14	DISCHARGES TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					451	47	588
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
12	TOTAL		146.21			451	47	588
13	RPCH VISITS							
24	RURAL HEALTH CLINIC		6.95					
25	TOTAL		153.16					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96 S-8 (09/2000)

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA

I PROVIDER NO: 14-1315 I COMPONENT NO: 14-3482
I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009
I PREPARED 2/24/2010 I WORKSHEET S-8

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 321 WEST WASHINGTON
1.01 CITY: PITTSFIELD STATE: IL ZIP CODE: 62363 COUNTY: PIKE
2 DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 2
3 COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT)		/ /
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /
5 HEALTH SERVICES FOR THE HOMELESS (SECTION 340(d), PHS ACT)		/ /
6 APPALACHIAN REGIONAL COMMISSION		/ /
7 LOOK-ALIKES		/ /
8 OTHER (SPECIFY)		/ /

PHYSICIAN INFORMATION:

		PHYSICIAN NAME	BILLING NUMBER
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		
		PHYSICIAN NAME	HOURS OF SUPERVISION
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.) N

FACILITY HOURS OF OPERATIONS (1)

		SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	TYPE OPERATION	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	CLINIC			700	1730	700	1730	700	1730	700	1730	700	1730	700	1200

(1) ENTER CLINIC HOURS OF OPERATIONS ON SUBSCRIPTS OF LINE 12 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? N

14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES. N

15 PROVIDER NAME: PROVIDER NUMBER:

		TITLE V	TITLE XVIII	TITLE XIX
16	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & RESIDENTS.	N		
17	HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS.			N

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		476,666	476,666	292,824	769,490
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		358,105	358,105	13,036	371,141
5	0500	EMPLOYEE BENEFITS		1,801,869	1,801,869		1,801,869
6	0600	ADMINISTRATIVE & GENERAL	1,041,932	1,383,408	2,425,340	-82,906	2,342,434
7	0700	MAINTENANCE & REPAIRS	277,904	175,605	453,509		453,509
8	0800	OPERATION OF PLANT		360,467	360,467	72,615	433,082
9	0900	LAUNDRY & LINEN SERVICE		73,154	73,154		73,154
10	1000	HOUSEKEEPING	243,585	34,779	278,364		278,364
11	1100	DIETARY	161,517	107,708	269,225		269,225
12	1200	CAFETERIA					
14	1400	NURSING ADMINISTRATION	106,672	30,562	137,234	-15,182	122,052
17	1700	MEDICAL RECORDS & LIBRARY	125,711	193,044	318,755		318,755
18	1800	SOCIAL SERVICE				50,577	50,577
20	2000	NONPHYSICIAN ANESTHETISTS				259,659	259,659
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	1,083,598	71,368	1,154,966	-51,712	1,103,254
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	405,886	117,440	523,326	-6,080	517,246
40	4000	ANESTHESIOLOGY	259,659	646	260,305	-260,305	
41	4100	RADIOLOGY-DIAGNOSTIC	634,244	768,736	1,402,980		1,402,980
41.01	3450	NUCLEAR MEDICINE-DIAGNOSTIC	28,313	171,222	199,535	-39,236	160,299
44	4400	LABORATORY	429,766	692,442	1,122,208	-84,917	1,037,291
49	4900	RESPIRATORY THERAPY	135,729	43,634	179,363	-21,567	157,796
49.01	4901	SLEEP STUDIES	32,134	5,958	38,092		38,092
50	5000	PHYSICAL THERAPY	25,754	30,307	56,061		56,061
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,457	133,929	173,386	154,322	327,708
56	5600	DRUGS CHARGED TO PATIENTS	265,969	1,697,817	1,963,786		1,963,786
56.01	5601	ONCOLOGY	88,031	225,723	313,754	-22	313,732
		OUTPAT SERVICE COST CNTRS					
61	6100	EMERGENCY	632,401	1,173,664	1,806,065	-15,629	1,790,436
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950	OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310	RURAL HEALTH CLINIC	248,732	633,901	882,633	14,910	897,543
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE		314,538	314,538	-280,387	34,151
90	9000	OTHER CAPITAL RELATED COSTS					
95		SUBTOTALS	6,266,994	11,076,692	17,343,686	-0-	17,343,686
		NONREIMBURS COST CENTERS					
	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800	PHYSICIANS' PRIVATE OFFICES	77,731	2,549	80,280		80,280
100	7950	AUTOMATED HEALTH SERVICES		169	169		169
100.01	7951	RENAL					
100.02	7952	LEASED SPACE					
100.03	7953	UNUSED SPACE					
101		TOTAL	6,344,725	11,079,410	17,424,135	-0-	17,424,135

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT		769,490
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		371,141
5	0500	EMPLOYEE BENEFITS	-675,117	1,126,752
6	0600	ADMINISTRATIVE & GENERAL	159,932	2,502,366
7	0700	MAINTENANCE & REPAIRS	-1,690	451,819
8	0800	OPERATION OF PLANT		433,082
9	0900	LAUNDRY & LINEN SERVICE	-1,684	71,470
10	1000	HOUSEKEEPING		278,364
11	1100	DIETARY	-52,870	216,355
12	1200	CAFETERIA		
14	1400	NURSING ADMINISTRATION		122,052
17	1700	MEDICAL RECORDS & LIBRARY	-6,813	311,942
18	1800	SOCIAL SERVICE		50,577
20	2000	NONPHYSICIAN ANESTHETISTS		259,659
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS		1,103,254
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM		517,246
40	4000	ANESTHESIOLOGY		
41	4100	RADIOLOGY-DIAGNOSTIC		1,402,980
41.01	3450	NUCLEAR MEDICINE-DIAGNOSTIC		160,299
44	4400	LABORATORY		1,037,291
49	4900	RESPIRATORY THERAPY		157,796
49.01	4901	SLEEP STUDIES		38,092
50	5000	PHYSICAL THERAPY		56,061
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,174	325,534
56	5600	DRUGS CHARGED TO PATIENTS		1,963,786
56.01	5601	ONCOLOGY	-208,000	105,732
		OUTPAT SERVICE COST CNTRS		
61	6100	EMERGENCY	-742,082	1,048,354
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310	RURAL HEALTH CLINIC	-56,966	840,577
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE	-34,151	-0-
90	9000	OTHER CAPITAL RELATED COSTS		-0-
95		SUBTOTALS	-1,621,615	15,722,071
		NONREIMBURS COST CENTERS		
	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800	PHYSICIANS' PRIVATE OFFICES		80,280
100	7950	AUTOMATED HEALTH SERVICES		169
100.01	7951	RENAL		
100.02	7952	LEASED SPACE		
100.03	7953	UNUSED SPACE		
101		TOTAL	-1,621,615	15,802,520

COST CENTERS USED IN COST REPORT

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I NOT A CMS WORKSHEET

E NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
41.01	NUCLEAR MEDICINE-DIAGNOSTIC	3450	NUCLEAR MEDICINE-DIAGNOSTIC
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
49.01	SLEEP STUDIES	4901	RESPIRATORY THERAPY
50	PHYSICAL THERAPY	5000	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
56.01	ONCOLOGY	5601	DRUGS CHARGED TO PATIENTS
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	AUTOMATED HEALTH SERVICES	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	RENAL	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	LEASED SPACE	7952	OTHER NONREIMBURSABLE COST CENTERS
100.03	UNUSED SPACE	7953	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	INCREASE SALARY	INCREASE OTHER
	1		2	3	4	5
1	RECLASS PROPERTY INSURANCE	A	OTHER CAPITAL RELATED COSTS	90		25,473
2	RECLASS UTILITIES	B	OPERATION OF PLANT	8		72,615
3	RECLASS MEDICAL SUPPLIES EXPENSE	C	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		154,322
4						
5						
6						
7						
8						
9						
10						
11	RECLASS INTEREST EXPENSE	D	NEW CAP REL COSTS-BLDG & FIXT	3		277,560
12			NEW CAP REL COSTS-MVBLE EQUIP	4		2,827
13	RECLASS SOCIAL SERVICE SALARY	E	SOCIAL SERVICE	18	50,577	
14	RECLASS MISCELLANEOUS ANTHES EXPENSE	F	OPERATING ROOM	37		646
15	RECLASS DIR OF PT CARE SALARY	G	NURSING ADMINISTRATION	14	89,215	
16	RECLASS CRNA COST	H	NONPHYSICIAN ANESTHETISTS	20	259,659	
17	RECLASS UR COORDINATOR SALARY	I	ADMINISTRATIVE & GENERAL	6	28,499	
18	RECLASS NURSING MANAGER SALARY	J	ADMINISTRATIVE & GENERAL	6	75,898	
19	RECLASS LPN WAGES	K	RURAL HEALTH CLINIC	63.50	15,094	
36	TOTAL RECLASSIFICATIONS				518,942	533,443

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

	EXPLANATION OF RECLASSIFICATION	CODE (1) 1	COST CENTER 6	DECREASE LINE NO 7	SALARY 8	OTHER 9	A-7 REF 10
1	RECLASS PROPERTY INSURANCE	A	ADMINISTRATIVE & GENERAL	6		25,473	
2	RECLASS UTILITIES	B	ADMINISTRATIVE & GENERAL	6		72,615	
3	RECLASS MEDICAL SUPPLIES EXPENSE	C	ADULTS & PEDIATRICS	25		1,135	
4			OPERATING ROOM	37		6,726	
5			NUCLEAR MEDICINE-DIAGNOSTIC	41.01		39,236	
6			LABORATORY	44		84,917	
7			RESPIRATORY THERAPY	49		21,567	
8			ONCOLOGY	56.01		22	
9			EMERGENCY	61		535	
10			RURAL HEALTH CLINIC	63.50		184	
11	RECLASS INTEREST EXPENSE	D	INTEREST EXPENSE	88		280,387	11
12							11
13	RECLASS SOCIAL SERVICE SALARY	E	ADULTS & PEDIATRICS	25	50,577		
14	RECLASS MISCELLANEOUS ANTHES EXPENSE	F	ANESTHESIOLOGY	40		646	
15	RECLASS DIR OF PT CARE SALARY	G	ADMINISTRATIVE & GENERAL	6	89,215		
16	RECLASS CRNA COST	H	ANESTHESIOLOGY	40	259,659		
17	RECLASS UR COORDINATOR SALARY	I	NURSING ADMINISTRATION	14	28,499		
18	RECLASS NURSING MANAGER SALARY	J	NURSING ADMINISTRATION	14	75,898		
19	RECLASS LPN WAGES	K	EMERGENCY	61	15,094		
36	TOTAL RECLASSIFICATIONS				518,942	533,443	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

RECLASS CODE: A
EXPLANATION : RECLASS PROPERTY INSURANCE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OTHER CAPITAL RELATED COSTS	90	25,473	ADMINISTRATIVE & GENERAL	6	25,473
TOTAL RECLASSIFICATIONS FOR CODE A			25,473			25,473

RECLASS CODE: B
EXPLANATION : RECLASS UTILITIES

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OPERATION OF PLANT	8	72,615	ADMINISTRATIVE & GENERAL	6	72,615
TOTAL RECLASSIFICATIONS FOR CODE B			72,615			72,615

RECLASS CODE: C
EXPLANATION : RECLASS MEDICAL SUPPLIES EXPENSE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	154,322	ADULTS & PEDIATRICS	25	1,135
2.00			0	OPERATING ROOM	37	6,726
3.00			0	NUCLEAR MEDICINE-DIAGNOSTIC	41.01	39,236
4.00			0	LABORATORY	44	84,917
5.00			0	RESPIRATORY THERAPY	49	21,567
6.00			0	ONCOLOGY	56.01	22
7.00			0	EMERGENCY	61	535
8.00			0	RURAL HEALTH CLINIC	63.50	184
TOTAL RECLASSIFICATIONS FOR CODE C			154,322			154,322

RECLASS CODE: D
EXPLANATION : RECLASS INTEREST EXPENSE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	277,560	INTEREST EXPENSE	88	280,387
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	2,827			0
TOTAL RECLASSIFICATIONS FOR CODE D			280,387			280,387

RECLASS CODE: E
EXPLANATION : RECLASS SOCIAL SERVICE SALARY

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	SOCIAL SERVICE	18	50,577	ADULTS & PEDIATRICS	25	50,577
TOTAL RECLASSIFICATIONS FOR CODE E			50,577			50,577

RECLASS CODE: F
EXPLANATION : RECLASS MISCELLANEOUS ANTHES EXPENSE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OPERATING ROOM	37	646	ANESTHESIOLOGY	40	646
TOTAL RECLASSIFICATIONS FOR CODE F			646			646

RECLASS CODE: G
EXPLANATION : RECLASS DIR OF PT CARE SALARY

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NURSING ADMINISTRATION	14	89,215	ADMINISTRATIVE & GENERAL	6	89,215
TOTAL RECLASSIFICATIONS FOR CODE G			89,215			89,215

RECLASS CODE: H
EXPLANATION : RECLASS CRNA COST

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NONPHYSICIAN ANESTHETISTS	20	259,659	ANESTHESIOLOGY	40	259,659
TOTAL RECLASSIFICATIONS FOR CODE H			259,659			259,659

RECLASS CODE: I
EXPLANATION : RECLASS UR COORDINATOR SALARY

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	28,499	NURSING ADMINISTRATION	14	28,499
TOTAL RECLASSIFICATIONS FOR CODE I			28,499			28,499

RECLASS CODE: J
EXPLANATION : RECLASS NURSING MANAGER SALARY

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	75,898	NURSING ADMINISTRATION	14	75,898
TOTAL RECLASSIFICATIONS FOR CODE J			75,898			75,898

RECLASS CODE: K
EXPLANATION : RECLASS LPN WAGES

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RURAL HEALTH CLINIC	63.50	15,094	EMERGENCY	61	15,094
TOTAL RECLASSIFICATIONS FOR CODE K			15,094			15,094

I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND	134,251					134,251	
2	LAND IMPROVEMENTS	214,956	6,500		6,500		221,456	
3	BUILDINGS & FIXTURE	6,448,376					6,448,376	
4	BUILDING IMPROVEMEN	765,639	75,724		75,724		841,363	
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	4,394,221	569,218		569,218	88,000	4,875,439	
7	SUBTOTAL	11,957,443	651,442		651,442	88,000	12,520,885	
8	RECONCILING ITEMS							
9	TOTAL	11,957,443	651,442		651,442	88,000	12,520,885	

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(12/1999)
RECONCILIATION OF CAPITAL COSTS CENTERS I PROVIDER NO: I PERIOD: I PREPARED 2/24/2010
I 14-1315 I FROM 10/ 1/2008 I WORKSHEET A-7
I I TO 9/30/2009 I PARTS III & IV

III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	GROSS ASSETS	COMPUTATION OF RATIOS CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	ALLOCATION OF OTHER CAPITAL INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	7,289,739		7,289,739	.599230	15,264			15,264
4	NEW CAP REL COSTS-MV	4,875,439		4,875,439	.400770	10,209			10,209
5	TOTAL	12,165,178		12,165,178	1.000000	25,473			25,473

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	476,666		277,560	15,264			769,490
4	NEW CAP REL COSTS-MV	358,105		2,827	10,209			371,141
5	TOTAL	834,771		280,387	25,473			1,140,631

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	476,666						476,666
4	NEW CAP REL COSTS-MV	358,105						358,105
5	TOTAL	834,771						834,771

* All lines numbers except line 5 are to be consistent with Workhseet A line numbers for capital cost centers.
(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4.
Columns 9 through 14 should include related Worksheet A-6 reclassifications and Worksheet A-8 adjustments. (See instructions).

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER	B	-34,151	INTEREST EXPENSE	88	
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES					
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-887,371			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1	-460,472			
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-2,417	DIETARY	11	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-6,813	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
	MISCELLANEOUS INCOME	B	-7,029	ADMINISTRATIVE & GENERAL	6	
	MISCELLANEOUS SUPPLIES REVENUE	B	-2,174	MEDICAL SUPPLIES CHARGED	55	
39	PHYSICIAN RECRUITMENT	A	-425	ADMINISTRATIVE & GENERAL	6	
40	CABLE TELEVISION	A	-1,690	MAINTENANCE & REPAIRS	7	
41	MISCELLANEOUS EXPENSE	A	-17,435	ADMINISTRATIVE & GENERAL	6	
42	PUBLIC RELATIONS SALARIES	A	-19,525	ADMINISTRATIVE & GENERAL	6	
43	PUBLIC RELATIONS EMPLOYEE BENEFITS	A	-5,545	EMPLOYEE BENEFITS	5	
44	PUBLIC RELATIONS EXPENSES	A	-81,066	ADMINISTRATIVE & GENERAL	6	
45	COFFEE SHOP RECEIPTS	B	-44,149	DIETARY	11	
46	MEALS ON WHEELS	B	-7,203	DIETARY	11	
47	LOBBYING EXPENSE	A	-8,708	ADMINISTRATIVE & GENERAL	6	
48	MISCELLANOUS	B	-775	ADMINISTRATIVE & GENERAL	6	
49	NON-RHC PHYSICIAN COST	A	-34,667	RURAL HEALTH CLINIC	63.50	
50	TOTAL (SUM OF LINES 1 THRU 49)		-1,621,615			

(1) Description - all chapter references in this columnpertain to CMS Pub. 15-I.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUST-MENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1 6	ADMINISTRATIVE & GENERAL	HOME OFFICE	700,345	405,450	294,895	
2 11	DIETARY	DIETICIAN	7,749	6,850	899	
3 9	LAUNDRY & LINEN SERVICE	LAUNDRY SERVICES	59,338	61,022	-1,684	
4 5	EMPLOYEE BENEFITS	HEALTH INSURANCE	390,319	1,059,891	-669,572	
4.01 63 50	RURAL HEALTH CLINIC	RHC PHYSICIAN	416,043	432,751	-16,708	
4.02 61	EMERGENCY	ER PHYSICIANS	1,037,223	1,099,934	-62,711	
4.03 63 50	RURAL HEALTH CLINIC	RHC CLINIC BUILDING	9,349	14,940	-5,591	
5	TOTALS		2,620,366	3,080,838	-460,472	

* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:
THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
1	B		0.00	BLESSING CORPORATE SVCS	0.00	HOME OFFICE
2	G		0.00	BLESSING HOSPITAL	0.00	HOSPITAL
3	G		0.00	DENMAN SERVICES	0.00	LAUNDRY AND BIO-MED
4			0.00		0.00	
5			0.00		0.00	

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
- B. CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
- C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
- D. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
- E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
- F. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
- G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.
  BROTHER/SISTER ENTITY

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 1		COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN-ERATION 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	44		LABORATORY	33,032		33,032				
2	56	1	ONCOLOGY	208,000	208,000					
3	61		EMERGENCY	1,052,103	679,371	372,732				
4	14		UM REVIEW	2,475		2,475				
5										
6										
7										
8										
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27										
28										
29										
30										
101			TOTAL	1,295,610	887,371	408,239				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 10		COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	44		LABORATORY							
2	56	1	ONCOLOGY							208,000
3	61		EMERGENCY							679,371
4	14		UM REVIEW							
5										
6										
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21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
101			TOTAL							887,371

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	112
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	107
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.45
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		222.68	243.78		
10	AHSEA (SEE INSTRUCTIONS)		68.57	51.43		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	34.29	34.29	25.72		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	15,269
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	12,538
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	27,807
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	27,807

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	59.61
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	46,496
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	46,496

PART III - SALARY AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE

24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	3,840
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	2,752
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	6,592
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	756
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	7,348

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
?	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	

J	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	7,348
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE	
36	THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)	
37	ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11)	
38	SUBTOTAL (SUM OF LINES 36 AND 37)	
39	STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6)	
40	THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)	
41	ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)	
42	SUBTOTAL (SUM OF LINES 40 AND 41)	
43	OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)	
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES; COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE	
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS)	
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)	
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)	

PART V - OVERTIME COMPUTATION

		THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
		1	2	3	4	5
	OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)					
48	OVERTIME RATE (SEE INSTRUCTIONS)					
	CALCULATION OF LIMIT					
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE)(MULTIPLY LINE 47 TIMES LINE 48)					
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
	DETERMINATION OF OVERTIME ALLOWANCE					
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53	OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54	MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56	OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO)(ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	46,496
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	7,348
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	53,844
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	20,792

	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	
PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES		
66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	20,792
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	20,792
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(7/2009)

COST ALLOCATION STATISTICS

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I NOT A CMS WORKSHEET

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	SQUARE FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	6	SQUARE FEET	ENTERED
8	OPERATION OF PLANT	7	SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	ENTERED
10	HOUSEKEEPING	9	SQUARE FEET	ENTERED
11	DIETARY	8	PATIENT DAYS	ENTERED
12	CAFETERIA	5	GROSS SALARIES	ENTERED
14	NURSING ADMINISTRATION	13	NURSING SALARIES	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TOTAL CHARGES	ENTERED
18	SOCIAL SERVICE	8	PATIENT DAYS	ENTERED
20	NONPHYSICIAN ANESTHETISTS	18	ASSIGNED TIME	ENTERED

		COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS
			0	3	4	5	5a.00	6	7
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &	769,490	769,490					
004		NEW CAP REL COSTS-MVBLE E	371,141		371,141				
005		EMPLOYEE BENEFITS	1,126,752			1,126,752			
006		ADMINISTRATIVE & GENERAL	2,502,366	147,906	81,583	184,833	2,916,688	2,916,688	
007		MAINTENANCE & REPAIRS	451,819	157,978	87,142	49,505	746,444	168,956	915,400
008		OPERATION OF PLANT	433,082				433,082	98,027	
009		LAUNDRY & LINEN SERVICE	71,470				71,470	16,177	
010		HOUSEKEEPING	278,364	12,338	6,805	43,391	340,898	77,162	26,747
011		DIETARY	216,355	15,056	8,304	28,772	268,487	60,771	32,638
012		CAFETERIA		5,442	3,002		8,444	1,911	11,797
014		NURSING ADMINISTRATION	122,052	1,726	952	16,298	141,028	31,921	3,741
017		MEDICAL RECORDS & LIBRARY	311,942	28,250	15,582	22,394	378,168	85,598	61,241
018		SOCIAL SERVICE	50,577	972	536	9,010	61,095	13,829	2,106
020		NONPHYSICIAN ANESTHETISTS	259,659			46,255	305,914	69,243	
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	1,103,254	74,585	41,140	184,019	1,402,998	317,566	161,689
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	517,246	46,220	25,494	72,303	661,263	149,676	100,197
040		ANESTHESIOLOGY							
041		RADIOLOGY-DIAGNOSTIC	1,402,980	33,087	18,250	112,982	1,567,299	354,755	71,727
041	01	NUCLEAR MEDICINE-DIAGNOST	160,299	3,513	1,937	5,044	170,793	38,659	7,615
044		LABORATORY	1,037,291	16,761	9,245	76,557	1,139,854	258,004	36,335
049		RESPIRATORY THERAPY	157,796	9,029	4,980	24,178	195,983	44,360	19,574
049	01	SLEEP STUDIES	38,092	3,234	1,784	5,724	48,834	11,053	7,011
050		PHYSICAL THERAPY	56,061	3,492	1,926	4,588	66,067	14,954	7,570
055		MEDICAL SUPPLIES CHARGED	325,534	10,232	5,644	7,029	348,439	78,868	22,181
056		DRUGS CHARGED TO PATIENTS	1,963,786	11,210	6,183	47,379	2,028,558	459,166	24,302
056	01	ONCOLOGY	105,732	5,068	2,796	15,682	129,278	29,262	10,987
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	1,048,354	41,661	22,980	109,965	1,222,960	276,815	90,315
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	840,577		10,871	46,997	898,445	203,361	42,727
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	15,722,071	627,760	357,136	1,112,905	15,552,489	2,860,094	740,500
		NONREIMBURS COST CENTERS							
		GIFT, FLOWER, COFFEE SHOP		5,231	2,886		8,117	1,837	11,341
		PHYSICIANS' PRIVATE OFFIC	80,280	20,158	11,119	13,847	125,404	28,385	43,699
100		AUTOMATED HEALTH SERVICES	169				169	38	
100	01	RENAL		15,647			15,647	3,542	33,920
100	02	LEASED SPACE		39,643			39,643	8,973	85,940
100	03	UNUSED SPACE		61,051			61,051	13,819	
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	15,802,520	769,490	371,141	1,126,752	15,802,520	2,916,688	915,400

		COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY
			8	9	10	11	12	14	17
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
007		MAINTENANCE & REPAIRS							
008		OPERATION OF PLANT	531,109						
009		LAUNDRY & LINEN SERVICE		87,647					
010		HOUSEKEEPING	14,611		459,418				
011		DIETARY	17,829		18,440	398,165			
012		CAFETERIA	6,445		6,665		35,262		
014		NURSING ADMINISTRATION	2,044		2,114		701	181,549	
017		MEDICAL RECORDS & LIBRARY	33,454		34,601		963		594,025
018		SOCIAL SERVICE	1,151		1,190		387		
020		NONPHYSICIAN ANESTHETISTS					1,988		
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	88,325	87,647	91,353	398,165	7,913	80,781	43,061
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	54,735		56,611		3,108	26,979	42,581
040		ANESTHESIOLOGY							3,685
041		RADIOLOGY-DIAGNOSTIC	39,183		40,525		4,857	7	163,395
041	01	NUCLEAR MEDICINE-DIAGNOST	4,160		4,302		217	2,627	21,312
044		LABORATORY	19,849		20,529		3,291		99,763
049		RESPIRATORY THERAPY	10,693		11,059		1,039	4,775	19,009
049	01	SLEEP STUDIES	3,830		3,961		246		5,393
050		PHYSICAL THERAPY	4,136		4,277		197		3,433
055		MEDICAL SUPPLIES CHARGED	12,117		12,532		302		21,816
056		DRUGS CHARGED TO PATIENTS	13,276		13,730		2,037		90,034
056	01	ONCOLOGY	6,002		6,208		674	7,478	3,465
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	49,337		51,027		4,727	46,738	77,078
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC					2,020	8,443	
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	381,177	87,647	379,124	398,165	34,667	177,828	594,025
		NONREIMBURS COST CENTERS							
		GIFT, FLOWER, COFFEE SHOP	6,195		6,408				
		PHYSICIANS' PRIVATE OFFIC	23,872		24,690		595	3,721	
100		AUTOMATED HEALTH SERVICES							
100	01	RENAL	18,529		19,164				
100	02	LEASED SPACE	29,037		30,032				
100	03	UNUSED SPACE	72,299						
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	531,109	87,647	459,418	398,165	35,262	181,549	594,025

		COST CENTER DESCRIPTION	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
			18	20	25	26	27
		GENERAL SERVICE COST CNTR					
003		NEW CAP REL COSTS-BLDG &					
004		NEW CAP REL COSTS-MVBLE E					
005		EMPLOYEE BENEFITS					
006		ADMINISTRATIVE & GENERAL					
007		MAINTENANCE & REPAIRS					
008		OPERATION OF PLANT					
009		LAUNDRY & LINEN SERVICE					
010		HOUSEKEEPING					
011		DIETARY					
012		CAFETERIA					
014		NURSING ADMINISTRATION					
017		MEDICAL RECORDS & LIBRARY					
018		SOCIAL SERVICE	79,758				
020		NONPHYSICIAN ANESTHETISTS		377,145			
		INPAT ROUTINE SRVC CNTRS					
025		ADULTS & PEDIATRICS	79,758		2,759,256		2,759,256
		ANCILLARY SRVC COST CNTRS					
037		OPERATING ROOM			1,095,150		1,095,150
040		ANESTHESIOLOGY		377,145	380,830		380,830
041		RADIOLOGY-DIAGNOSTIC			2,241,748		2,241,748
041	01	NUCLEAR MEDICINE-DIAGNOST			249,685		249,685
044		LABORATORY			1,577,625		1,577,625
049		RESPIRATORY THERAPY			306,492		306,492
049	01	SLEEP STUDIES			80,328		80,328
050		PHYSICAL THERAPY			100,634		100,634
055		MEDICAL SUPPLIES CHARGED			496,255		496,255
056		DRUGS CHARGED TO PATIENTS			2,631,103		2,631,103
056	01	ONCOLOGY			193,354		193,354
		OUTPAT SERVICE COST CNTRS					
061		EMERGENCY			1,818,997		1,818,997
062		OBSERVATION BEDS (NON-DIS					
063		OTHER OUTPATIENT SERVICE					
063	50	RURAL HEALTH CLINIC			1,154,996		1,154,996
		SPEC PURPOSE COST CENTERS					
095		SUBTOTALS	79,758	377,145	15,086,453		15,086,453
		NONREIMBURS COST CENTERS					
		GIFT, FLOWER, COFFEE SHOP			33,898		33,898
		PHYSICIANS' PRIVATE OFFIC			250,366		250,366
100		AUTOMATED HEALTH SERVICES			207		207
100	01	RENAL			90,802		90,802
100	02	LEASED SPACE			193,625		193,625
100	03	UNUSED SPACE			147,169		147,169
101		CROSS FOOT ADJUSTMENT					
102		NEGATIVE COST CENTER					
103		TOTAL	79,758	377,145	15,802,520		15,802,520

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET B I PART III

		COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS
			0	3	4	4a	5	6	7
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS						229,489	
006		ADMINISTRATIVE & GENERAL		147,906	81,583	229,489		13,293	258,413
007		MAINTENANCE & REPAIRS		157,978	87,142	245,120		7,713	
008		OPERATION OF PLANT						1,273	
009		LAUNDRY & LINEN SERVICE						6,071	7,550
010		HOUSEKEEPING		12,338	6,805	19,143		4,781	9,214
011		DIETARY		15,056	8,304	23,360		150	3,330
012		CAFETERIA		5,442	3,002	8,444		2,512	1,056
014		NURSING ADMINISTRATION		1,726	952	2,678		6,735	17,288
017		MEDICAL RECORDS & LIBRARY		28,250	15,582	43,832		1,088	595
018		SOCIAL SERVICE		972	536	1,508		5,448	
020		NONPHYSICIAN ANESTHETISTS							
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS		74,585	41,140	115,725		24,986	45,644
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM		46,220	25,494	71,714		11,776	28,285
040		ANESTHESIOLOGY							
041		RADIOLOGY-DIAGNOSTIC		33,087	18,250	51,337		27,912	20,248
041	01	NUCLEAR MEDICINE-DIAGNOST		3,513	1,937	5,450		3,042	2,150
044		LABORATORY		16,761	9,245	26,006		20,300	10,257
049		RESPIRATORY THERAPY		9,029	4,980	14,009		3,490	5,526
049	01	SLEEP STUDIES		3,234	1,784	5,018		870	1,979
050		PHYSICAL THERAPY		3,492	1,926	5,418		1,177	2,137
055		MEDICAL SUPPLIES CHARGED		10,232	5,644	15,876		6,205	6,262
056		DRUGS CHARGED TO PATIENTS		11,210	6,183	17,393		36,132	6,860
056	01	ONCOLOGY		5,068	2,796	7,864		2,302	3,102
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY		41,661	22,980	64,641		21,780	25,495
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC			10,871	10,871		16,000	12,062
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS		627,760	357,136	984,896		225,036	209,040
		NONREIMBURS COST CENTERS							
		GIFT, FLOWER, COFFEE SHOP		5,231	2,886	8,117		145	3,201
		PHYSICIANS' PRIVATE OFFIC		20,158	11,119	31,277		2,233	12,336
100		AUTOMATED HEALTH SERVICES						3	
100	01	RENAL		15,647		15,647		279	9,575
100	02	LEASED SPACE		39,643		39,643		706	24,261
100	03	UNUSED SPACE		61,051		61,051		1,087	
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL		769,490	371,141	1,140,631		229,489	258,413

		COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY
			8	9	10	11	12	14	17
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
007		MAINTENANCE & REPAIRS							
008		OPERATION OF PLANT	7,713						
009		LAUNDRY & LINEN SERVICE		1,273					
010		HOUSEKEEPING	212		32,976				
011		DIETARY	259		1,324	38,938			
012		CAFETERIA	94		478		12,496		
014		NURSING ADMINISTRATION	30		152		248	6,676	
017		MEDICAL RECORDS & LIBRARY	486		2,484		341		71,166
018		SOCIAL SERVICE	17		85		137		
020		NONPHYSICIAN ANESTHETISTS					705		
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	1,282	1,273	6,554	38,938	2,804	2,970	5,159
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	795		4,063		1,102	992	5,101
040		ANESTHESIOLOGY							442
041		RADIOLOGY-DIAGNOSTIC	569		2,909		1,721		19,576
041	01	NUCLEAR MEDICINE-DIAGNOST	60		309		77	97	2,553
044		LABORATORY	288		1,474		1,166		11,952
049		RESPIRATORY THERAPY	155		794		368	176	2,277
049	01	SLEEP STUDIES	56		284		87		646
050		PHYSICAL THERAPY	60		307		70		411
055		MEDICAL SUPPLIES CHARGED	176		900		107		2,614
056		DRUGS CHARGED TO PATIENTS	193		986		722		10,786
056	01	ONCOLOGY	87		446		239	275	415
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	716		3,663		1,675	1,719	9,234
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC					716	310	
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	5,535	1,273	27,212	38,938	12,285	6,539	71,166
		NONREIMBURS COST CENTERS							
		GIFT, FLOWER, COFFEE SHOP	90		460				
		PHYSICIANS' PRIVATE OFFIC	347		1,772		211	137	
100		AUTOMATED HEALTH SERVICES							
100	01	RENAL	269		1,376				
100	02	LEASED SPACE	422		2,156				
100	03	UNUSED SPACE	1,050						
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL	7,713	1,273	32,976	38,938	12,496	6,676	71,166

		COST CENTER DESCRIPTION	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
			18	20	25	26	27
		GENERAL SERVICE COST CNTR					
003		NEW CAP REL COSTS-BLDG &					
004		NEW CAP REL COSTS-MVBLE E					
005		EMPLOYEE BENEFITS					
006		ADMINISTRATIVE & GENERAL					
007		MAINTENANCE & REPAIRS					
008		OPERATION OF PLANT					
009		LAUNDRY & LINEN SERVICE					
010		HOUSEKEEPING					
011		DIETARY					
012		CAFETERIA					
014		NURSING ADMINISTRATION					
017		MEDICAL RECORDS & LIBRARY					
018		SOCIAL SERVICE	3,430				
020		NONPHYSICIAN ANESTHETISTS		6,153			
		INPAT ROUTINE SRVC CNTRS					
025		ADULTS & PEDIATRICS	3,430		248,765		248,765
		ANCILLARY SRVC COST CNTRS					
037		OPERATING ROOM			123,828		123,828
040		ANESTHESIOLOGY			442		442
041		RADIOLOGY-DIAGNOSTIC			124,272		124,272
041	01	NUCLEAR MEDICINE-DIAGNOST			13,738		13,738
044		LABORATORY			71,443		71,443
049		RESPIRATORY THERAPY			26,795		26,795
049	01	SLEEP STUDIES			8,940		8,940
050		PHYSICAL THERAPY			9,580		9,580
055		MEDICAL SUPPLIES CHARGED			32,140		32,140
056		DRUGS CHARGED TO PATIENTS			73,072		73,072
056	01	ONCOLOGY			14,730		14,730
		OUTPAT SERVICE COST CNTRS					
061		EMERGENCY			128,923		128,923
062		OBSERVATION BEDS (NON-DIS					
063		OTHER OUTPATIENT SERVICE					
063	50	RURAL HEALTH CLINIC			39,959		39,959
		SPEC PURPOSE COST CENTERS					
095		SUBTOTALS	3,430		916,627		916,627
		NONREIMBURS COST CENTERS					
		GIFT, FLOWER, COFFEE SHOP			12,013		12,013
		PHYSICIANS' PRIVATE OFFIC			48,313		48,313
100		AUTOMATED HEALTH SERVICES			3		3
100	01	RENAL			27,146		27,146
100	02	LEASED SPACE			67,188		67,188
100	03	UNUSED SPACE			63,188		63,188
101		CROSS FOOT ADJUSTMENTS		6,153	6,153		6,153
102		NEGATIVE COST CENTER					
103		TOTAL	3,430	6,153	1,140,631		1,140,631

	COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-MVBLE & (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)
		3	4	5	6a.00	6	7
	GENERAL SERVICE COST						
003	NEW CAP REL COSTS-BLD	113,260					
004	NEW CAP REL COSTS-MVB		99,037				
005	EMPLOYEE BENEFITS			6,325,200			
006	ADMINISTRATIVE & GENE	21,770	21,770	1,037,589	-2,916,688	12,885,832	
007	MAINTENANCE & REPAIRS	23,253	23,253	277,904		746,444	62,152
008	OPERATION OF PLANT					433,082	
009	LAUNDRY & LINEN SERVI					71,470	
010	HOUSEKEEPING	1,816	1,816	243,584		340,898	1,816
011	DIETARY	2,216	2,216	161,517		268,487	2,216
012	CAFETERIA	801	801			8,444	801
014	NURSING ADMINISTRATIO	254	254	91,490		141,028	254
017	MEDICAL RECORDS & LIB	4,158	4,158	125,711		378,168	4,158
018	SOCIAL SERVICE	143	143	50,577		61,095	143
020	NONPHYSICIAN ANESTHET			259,659		305,914	
	INPAT ROUTINE SRVC CN						
025	ADULTS & PEDIATRICS	10,978	10,978	1,033,021		1,402,998	10,978
	ANCILLARY SRVC COST C						
037	OPERATING ROOM	6,803	6,803	405,886		661,263	6,803
040	ANESTHESIOLOGY						
041	RADIOLOGY-DIAGNOSTIC	4,870	4,870	634,244		1,567,299	4,870
041 01	NUCLEAR MEDICINE-DIAG	517	517	28,313		170,793	517
044	LABORATORY	2,467	2,467	429,766		1,139,854	2,467
049	RESPIRATORY THERAPY	1,329	1,329	135,729		195,983	1,329
049 01	SLEEP STUDIES	476	476	32,134		48,834	476
050	PHYSICAL THERAPY	514	514	25,754		66,067	514
055	MEDICAL SUPPLIES CHAR	1,506	1,506	39,457		348,439	1,506
056	DRUGS CHARGED TO PATI	1,650	1,650	265,969		2,028,558	1,650
056 01	ONCOLOGY	746	746	88,031		129,278	746
	OUTPAT SERVICE COST C						
061	EMERGENCY	6,132	6,132	617,307		1,222,960	6,132
062	OBSERVATION BEDS (NON						
063	OTHER OUTPATIENT SERV						
50	RURAL HEALTH CLINIC		2,901	263,826		898,445	2,901
	SPEC PURPOSE COST CEN						
095	SUBTOTALS	92,399	95,300	6,247,468	-2,916,688	12,635,801	50,277
	NONREIMBURS COST CENT						
096	GIFT, FLOWER, COFFEE	770	770			8,117	770
098	PHYSICIANS' PRIVATE O	2,967	2,967	77,732		125,404	2,967
100	AUTOMATED HEALTH SERV					169	
100 01	RENAL	2,303				15,647	2,303
100 02	LEASED SPACE	5,835				39,643	5,835
100 03	UNUSED SPACE	8,986				61,051	
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	769,490	371,141	1,126,752		2,916,688	915,400
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	6.794014	3.747498	.178137		.226348	14.728408
105	COST TO BE ALLOCATED (WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107	COST TO BE ALLOCATED (WRKSHT B, PART III					229,489	258,413
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)					.017809	4.157758

	COST CENTER DESCRIPTION	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (TOTAL CHARGES)
		8	9	10	11	12	14	17
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
007	MAINTENANCE & REPAIRS							
008	OPERATION OF PLANT	66,011						
009	LAUNDRY & LINEN SERVI		1,997					
010	HOUSEKEEPING	1,816		55,209				
011	DIETARY	2,216		2,216	1,997			
012	CAFETERIA	801		801		4,604,606		
014	NURSING ADMINISTRATIO	254		254		91,490	1,940,217	
017	MEDICAL RECORDS & LIB	4,158		4,158		125,711		34,713,999
018	SOCIAL SERVICE	143		143		50,577		
020	NONPHYSICIAN ANESTHET					259,659		
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	10,978	1,997	10,978	1,997	1,033,021	863,302	2,516,425
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	6,803		6,803		405,886	288,327	2,488,356
040	ANESTHESIOLOGY							215,369
041	RADIOLOGY-DIAGNOSTIC	4,870		4,870		634,244	80	9,548,524
041 01	NUCLEAR MEDICINE-DIAG	517		517		28,313	28,073	1,245,455
044	LABORATORY	2,467		2,467		429,766		5,830,020
049	RESPIRATORY THERAPY	1,329		1,329		135,729	51,027	1,110,866
049 01	SLEEP STUDIES	476		476		32,134		315,171
050	PHYSICAL THERAPY	514		514		25,754		200,634
055	MEDICAL SUPPLIES CHAR	1,506		1,506		39,457		1,274,924
056	DRUGS CHARGED TO PATI	1,650		1,650		265,969		5,261,436
056 01	ONCOLOGY	746		746		88,031	79,920	202,504
	OUTPAT SERVICE COST C							
061	EMERGENCY	6,132		6,132		617,307	499,492	4,504,315
062	OBSERVATION BEDS (NON							
063	OTHER OUTPATIENT SERV							
50	RURAL HEALTH CLINIC					263,826	90,233	
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	47,376	1,997	45,560	1,997	4,526,874	1,900,454	34,713,999
	NONREIMBURS COST CENT							
096	GIFT, FLOWER, COFFEE	770		770				
098	PHYSICIANS' PRIVATE O	2,967		2,967		77,732	39,763	
100	AUTOMATED HEALTH SERV							
100 01	RENAL	2,303		2,303				
100 02	LEASED SPACE	3,609		3,609				
100 03	UNUSED SPACE	8,986						
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	531,109	87,647	459,418	398,165	35,262	181,549	594,025
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	8.045765	43.889334	8.321433	199.381572	.007658	.093571	.017112
105	COST TO BE ALLOCATED (WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107	COST TO BE ALLOCATED (WRKSHT B, PART III	7,713	1,273	32,976	38,938	12,496	6,676	71,166
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.116844	.637456	.597294	19.498247	.002714	.003441	.002050

	COST CENTER DESCRIPTION	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)
		18	20
	GENERAL SERVICE COST		
003	NEW CAP REL COSTS-BLD		
004	NEW CAP REL COSTS-MVB		
005	EMPLOYEE BENEFITS		
006	ADMINISTRATIVE & GENE		
007	MAINTENANCE & REPAIRS		
008	OPERATION OF PLANT		
009	LAUNDRY & LINEN SERVI		
010	HOUSEKEEPING		
011	DIETARY		
012	CAFETERIA		
014	NURSING ADMINISTRATIO		
017	MEDICAL RECORDS & LIB		
018	SOCIAL SERVICE	1,997	
020	NONPHYSICIAN ANESTHET		100
	INPAT ROUTINE SRVC CN		
025	ADULTS & PEDIATRICS	1,997	
	ANCILLARY SRVC COST C		
037	OPERATING ROOM		
040	ANESTHESIOLOGY		100
041	RADIOLOGY-DIAGNOSTIC		
041 01	NUCLEAR MEDICINE-DIAG		
044	LABORATORY		
049	RESPIRATORY THERAPY		
049 01	SLEEP STUDIES		
050	PHYSICAL THERAPY		
055	MEDICAL SUPPLIES CHAR		
056	DRUGS CHARGED TO PATI		
056 01	ONCOLOGY		
	OUTPAT SERVICE COST C		
061	EMERGENCY		
062	OBSERVATION BEDS (NON		
063	OTHER OUTPATIENT SERV		
50	RURAL HEALTH CLINIC		
	SPEC PURPOSE COST CEN		
095	SUBTOTALS	1,997	100
	NONREIMBURS COST CENT		
096	GIFT, FLOWER, COFFEE		
098	PHYSICIANS' PRIVATE O		
100	AUTOMATED HEALTH SERV		
100 01	RENAL		
100 02	LEASED SPACE		
100 03	UNUSED SPACE		
101	CROSS FOOT ADJUSTMENT		
102	NEGATIVE COST CENTER		
103	COST TO BE ALLOCATED (PER WRKSHT B, PART	79,758	377,145
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	39.938908	3,771.450000
105	COST TO BE ALLOCATED (PER WRKSHT B, PART		
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)		
107	COST TO BE ALLOCATED (PER WRKSHT B, PART	3,430	6,153
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	1.717576	61.530000

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET C I PART I

WKST A ( ) NO.		COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
		INPAT ROUTINE SRVC CNTRS					
25		ADULTS & PEDIATRICS	2,759,256		2,759,256		
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	1,095,150		1,095,150		
40		ANESTHESIOLOGY	380,830		380,830		
41		RADIOLOGY-DIAGNOSTIC	2,241,748		2,241,748		
41	01	NUCLEAR MEDICINE-DIAGNOST	249,685		249,685		
44		LABORATORY	1,577,625		1,577,625		
49		RESPIRATORY THERAPY	306,492		306,492		
49	01	SLEEP STUDIES	80,328		80,328		
50		PHYSICAL THERAPY	100,634		100,634		
55		MEDICAL SUPPLIES CHARGED	496,255		496,255		
56		DRUGS CHARGED TO PATIENTS	2,631,103		2,631,103		
56	01	ONCOLOGY	193,354		193,354		
		OUTPAT SERVICE COST CNTRS					
61		EMERGENCY	1,818,997		1,818,997		
62		OBSERVATION BEDS (NON-DIS	212,789		212,789		
63		OTHER OUTPATIENT SERVICE					
63	50	RURAL HEALTH CLINIC	1,154,996		1,154,996		
		OTHER REIMBURS COST CNTRS					
101		SUBTOTAL	15,299,242		15,299,242		
102		LESS OBSERVATION BEDS	212,789		212,789		
103		TOTAL	15,086,453		15,086,453		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET C I PART I

WKST A NO.		COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	2,243,425		2,243,425			
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	240,348	2,248,008	2,488,356	.440110	.440110	
40		ANESTHESIOLOGY	58,206	157,163	215,369	1.768267	1.768267	
41		RADIOLOGY-DIAGNOSTIC	603,452	8,945,072	9,548,524	.234774	.234774	
41	01	NUCLEAR MEDICINE-DIAGNOST	14,948	1,230,507	1,245,455	.200477	.200477	
44		LABORATORY	818,620	5,011,400	5,830,020	.270604	.270604	
49		RESPIRATORY THERAPY	308,793	802,073	1,110,866	.275904	.275904	
49	01	SLEEP STUDIES		315,171	315,171	.254871	.254871	
50		PHYSICAL THERAPY	190,501	10,133	200,634	.501580	.501580	
55		MEDICAL SUPPLIES CHARGED	714,355	560,569	1,274,924	.389243	.389243	
56		DRUGS CHARGED TO PATIENTS	1,137,450	4,123,986	5,261,436	.500073	.500073	
56	01	ONCOLOGY	378	202,126	202,504	.954816	.954816	
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	42,690	4,461,625	4,504,315	.403834	.403834	
62		OBSERVATION BEDS (NON-DIS		273,000	273,000	.779447	.779447	
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC		1,030,066	1,030,066	1.121283	1.121283	
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	6,373,166	29,370,899	35,744,065			
102		LESS OBSERVATION BEDS						
103		TOTAL	6,373,166	29,370,899	35,744,065			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

WKST A NO.		COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
		INPAT ROUTINE SRVC CNTRS					
25		ADULTS & PEDIATRICS	2,759,256		2,759,256		
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	1,095,150		1,095,150		
40		ANESTHESIOLOGY	380,830		380,830		
41		RADIOLOGY-DIAGNOSTIC	2,241,748		2,241,748		
41	01	NUCLEAR MEDICINE-DIAGNOST	249,685		249,685		
44		LABORATORY	1,577,625		1,577,625		
49		RESPIRATORY THERAPY	306,492		306,492		
49	01	SLEEP STUDIES	80,328		80,328		
50		PHYSICAL THERAPY	100,634		100,634		
55		MEDICAL SUPPLIES CHARGED	496,255		496,255		
56		DRUGS CHARGED TO PATIENTS	2,631,103		2,631,103		
56	01	ONCOLOGY	193,354		193,354		
		OUTPAT SERVICE COST CNTRS					
61		EMERGENCY	1,818,997		1,818,997		
62		OBSERVATION BEDS (NON-DIS	212,789		212,789		
63		OTHER OUTPATIENT SERVICE					
63	50	RURAL HEALTH CLINIC	1,154,996		1,154,996		
		OTHER REIMBURS COST CNTRS					
101		SUBTOTAL	15,299,242		15,299,242		
102		LESS OBSERVATION BEDS	212,789		212,789		
103		TOTAL	15,086,453		15,086,453		

WKST A NO.		COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	2,243,425		2,243,425			
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	240,348	2,248,008	2,488,356	.440110	.440110	
40		ANESTHESIOLOGY	58,206	157,163	215,369	1.768267	1.768267	
41		RADIOLOGY-DIAGNOSTIC	603,452	8,945,072	9,548,524	.234774	.234774	
41	01	NUCLEAR MEDICINE-DIAGNOST	14,948	1,230,507	1,245,455	.200477	.200477	
44		LABORATORY	818,620	5,011,400	5,830,020	.270604	.270604	
49		RESPIRATORY THERAPY	308,793	802,073	1,110,866	.275904	.275904	
49	01	SLEEP STUDIES		315,171	315,171	.254871	.254871	
50		PHYSICAL THERAPY	190,501	10,133	200,634	.501580	.501580	
55		MEDICAL SUPPLIES CHARGED	714,355	560,569	1,274,924	.389243	.389243	
56		DRUGS CHARGED TO PATIENTS	1,137,450	4,123,986	5,261,436	.500073	.500073	
56	01	ONCOLOGY	378	202,126	202,504	.954816	.954816	
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	42,690	4,461,625	4,504,315	.403834	.403834	
62		OBSERVATION BEDS (NON-DIS		273,000	273,000	.779447	.779447	
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC		1,030,066	1,030,066	1.121283	1.121283	
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	6,373,166	29,370,899	35,744,065			
102		LESS OBSERVATION BEDS						
103		TOTAL	6,373,166	29,370,899	35,744,065			

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET C I PART II

LA NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	1,095,150	123,828	971,322			1,095,150
40		ANESTHESIOLOGY	380,830	442	380,388			380,830
41		RADIOLOGY-DIAGNOSTIC	2,241,748	124,272	2,117,476			2,241,748
41	01	NUCLEAR MEDICINE-DIAGNOST	249,685	13,738	235,947			249,685
44		LABORATORY	1,577,625	71,443	1,506,182			1,577,625
49		RESPIRATORY THERAPY	306,492	26,795	279,697			306,492
49	01	SLEEP STUDIES	80,328	8,940	71,388			80,328
50		PHYSICAL THERAPY	100,634	9,580	91,054			100,634
55		MEDICAL SUPPLIES CHARGED	496,255	32,140	464,115			496,255
56		DRUGS CHARGED TO PATIENTS	2,631,103	73,072	2,558,031			2,631,103
56	01	ONCOLOGY	193,354	14,730	178,624			193,354
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	1,818,997	128,923	1,690,074			1,818,997
62		OBSERVATION BEDS (NON-DIS	212,789		212,789			212,789
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	1,154,996	39,959	1,115,037			1,154,996
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	12,539,986	667,862	11,872,124			12,539,986
102		LESS OBSERVATION BEDS	212,789		212,789			212,789
103		TOTAL	12,327,197	667,862	11,659,335			12,327,197

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS | PROVIDER NO: 14-1315 | PERIOD: FROM 10/ 1/2008 TO 9/30/2009 | PREPARED 2/24/2010 | WORKSHEET C | PART II

LINE NO.	A	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
			7	8	9
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	2,488,356	.440110	.440110
40		ANESTHESIOLOGY	215,369	1.768267	1.768267
41		RADIOLOGY-DIAGNOSTIC	9,548,524	.234774	.234774
41	01	NUCLEAR MEDICINE-DIAGNOST	1,245,455	.200477	.200477
44		LABORATORY	5,830,020	.270604	.270604
49		RESPIRATORY THERAPY	1,110,866	.275904	.275904
49	01	SLEEP STUDIES	315,171	.254871	.254871
50		PHYSICAL THERAPY	200,634	.501580	.501580
55		MEDICAL SUPPLIES CHARGED	1,274,924	.389243	.389243
56		DRUGS CHARGED TO PATIENTS	5,261,436	.500073	.500073
56	01	ONCOLOGY	202,504	.954816	.954816
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	4,504,315	.403834	.403834
62		OBSERVATION BEDS (NON-DIS	273,000	.779447	.779447
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	1,030,066	1.121283	1.121283
		OTHER REIMBURS COST CNTRS			
101		SUBTOTAL	33,500,640		
102		LESS OBSERVATION BEDS	273,000		
103		TOTAL	33,227,640		

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET
PROVIDER NO: 14-1315 PERIOD: FROM 10/ 1/2008 TO 9/30/2009 PREPARED 2/24/2010 WORKSHEET C PART II

L.	A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	1,095,150	123,828	971,322			1,095,150
40		ANESTHESIOLOGY	380,830	442	380,388			380,830
41		RADIOLOGY-DIAGNOSTIC	2,241,748	124,272	2,117,476			2,241,748
41	01	NUCLEAR MEDICINE-DIAGNOST	249,685	13,738	235,947			249,685
44		LABORATORY	1,577,625	71,443	1,506,182			1,577,625
49		RESPIRATORY THERAPY	306,492	26,795	279,697			306,492
49	01	SLEEP STUDIES	80,328	8,940	71,388			80,328
50		PHYSICAL THERAPY	100,634	9,580	91,054			100,634
55		MEDICAL SUPPLIES CHARGED	496,255	32,140	464,115			496,255
56		DRUGS CHARGED TO PATIENTS	2,631,103	73,072	2,558,031			2,631,103
56	01	ONCOLOGY	193,354	14,730	178,624			193,354
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	1,818,997	128,923	1,690,074			1,818,997
62		OBSERVATION BEDS (NON-DIS	212,789		212,789			212,789
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	1,154,996	39,959	1,115,037			1,154,996
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	12,539,986	667,862	11,872,124			12,539,986
102		LESS OBSERVATION BEDS	212,789		212,789			212,789
103		TOTAL	12,327,197	667,862	11,659,335			12,327,197

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET C I PART II

LA NO.		COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
			7	8	9
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	2,488,356	.440110	.440110
40		ANESTHESIOLOGY	215,369	1.768267	1.768267
41		RADIOLOGY-DIAGNOSTIC	9,548,524	.234774	.234774
41	01	NUCLEAR MEDICINE-DIAGNOST	1,245,455	.200477	.200477
44		LABORATORY	5,830,020	.270604	.270604
49		RESPIRATORY THERAPY	1,110,866	.275904	.275904
49	01	SLEEP STUDIES	315,171	.254871	.254871
50		PHYSICAL THERAPY	200,634	.501580	.501580
55		MEDICAL SUPPLIES CHARGED	1,274,924	.389243	.389243
56		DRUGS CHARGED TO PATIENTS	5,261,436	.500073	.500073
56	01	ONCOLOGY	202,504	.954816	.954816
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	4,504,315	.403834	.403834
62		OBSERVATION BEDS (NON-DIS	273,000	.779447	.779447
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	1,030,066	1.121283	1.121283
		OTHER REIMBURS COST CNTRS			
101		SUBTOTAL	33,500,640		
102		LESS OBSERVATION BEDS	273,000		
103		TOTAL	33,227,640		

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1997)

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET C I PART III

L	A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	1,095,150	2,488,356			
40		ANESTHESIOLOGY	380,830	215,369			
41		RADIOLOGY-DIAGNOSTIC	2,241,748	9,548,524			
41	01	NUCLEAR MEDICINE-DIAGNOST	249,685	1,245,455			
44		LABORATORY	1,577,625	5,830,020			
49		RESPIRATORY THERAPY	306,492	1,110,866			
49	01	SLEEP STUDIES	80,328	315,171			
50		PHYSICAL THERAPY	100,634	200,634			
55		MEDICAL SUPPLIES CHARGED	496,255	1,274,924			
56		DRUGS CHARGED TO PATIENTS	2,631,103	5,261,436			
56	01	ONCOLOGY	193,354	202,504			
		OUTPAT SERVICE COST CNTRS					
61		EMERGENCY	1,818,997	4,504,315			
62		OBSERVATION BEDS (NON-DIS	212,789	273,000			
63		OTHER OUTPATIENT SERVICE					
63	50	RURAL HEALTH CLINIC	1,154,996	1,030,066			
		OTHER REIMBURS COST CNTRS					
101		TOTAL	12,539,986	33,500,640			

COMPUTATION OF OUTPATIENT COST PER VISIT - RURAL PRIMARY CARE HOSPITAL

PROVIDER NO: 14-1315 | PERIOD: FROM 10/ 1/2008 TO 9/30/2009 | PREPARED 2/24/2010 | WORKSHEET C PART V

LINE NO.	A	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT-PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT-PATIENT COSTS 7
		ANCILLARY SRVC COST CNTRS							
37		OPERATING ROOM	1,095,150		1,095,150	2,488,356			
40		ANESTHESIOLOGY	380,830		380,830	215,369			
41		RADIOLOGY-DIAGNOSTIC	2,241,748		2,241,748	9,548,524			
41	01	NUCLEAR MEDICINE-DIAGNOST	249,685		249,685	1,245,455			
44		LABORATORY	1,577,625		1,577,625	5,830,020			
49		RESPIRATORY THERAPY	306,492		306,492	1,110,866			
49	01	SLEEP STUDIES	80,328		80,328	315,171			
50		PHYSICAL THERAPY	100,634		100,634	200,634			
55		MEDICAL SUPPLIES CHARGED	496,255		496,255	1,274,924			
56		DRUGS CHARGED TO PATIENTS	2,631,103		2,631,103	5,261,436			
56	01	ONCOLOGY	193,354	208,000	401,354	202,504			
		OUTPAT SERVICE COST CNTRS							
61		EMERGENCY	1,818,997	679,371	2,498,368	4,504,315			
62		OBSERVATION BEDS (NON-DIS	212,789		212,789	273,000			
63		OTHER OUTPATIENT SERVICE							
63	50	RURAL HEALTH CLINIC							
		OTHER REIMBURS COST CNTRS							
101		TOTAL	11,384,990	887,371	12,272,361	32,470,574			
102		TOTAL OUTPATIENT VISITS							
103		AGGREGATE COST PER VISIT							
104		TITLE V OUTPATIENT VISITS							
105		TITLE XVIII OUTPAT VISITS							
106		TITLE XIX OUTPAT VISITS							
107		TITLE V OUTPAT COSTS							
108		TITLE XVIII OUTPAT COSTS							
109		TITLE XIX OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1315 | PERIOD: FROM 10/ 1/2008 TO 9/30/2009 | PREPARED 2/24/2010 | WORKSHEET D | PART V

	TITLE XVIII, PART B	HOSPITAL				
		Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
	Cost Center Description	1	1.01	1.02	2	3
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.440110		.440110		
40	ANESTHESIOLOGY	1.768267		1.768267		
41	RADIOLOGY-DIAGNOSTIC	.234774		.234774		
41 01	NUCLEAR MEDICINE-DIAGNOSTIC	.200477		.200477		
44	LABORATORY	.270604		.270604		
49	RESPIRATORY THERAPY	.275904		.275904		
49 01	SLEEP STUDIES	.254871		.254871		
50	PHYSICAL THERAPY	.501580		.501580		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.389243		.389243		
56	DRUGS CHARGED TO PATIENTS	.500073		.500073		
56 01	ONCOLOGY	.954816		.954816		
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.403834		.403834		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.779447		.779447		
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1315 | PERIOD: FROM 10/ 1/2008 TO 9/30/2009 | PREPARED 2/24/2010 | WORKSHEET D PART V

	TITLE XVIII, PART B	HOSPITAL					
			Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	Cost Center Description		4	5	6	7	8
(A)	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM			1,091,962			
40	ANESTHESIOLOGY			61,846			
41	RADIOLOGY-DIAGNOSTIC			3,690,476			
41	01 NUCLEAR MEDICINE-DIAGNOSTIC			758,453			
44	LABORATORY			1,943,655			
49	RESPIRATORY THERAPY			449,496			
49	01 SLEEP STUDIES			166,620			
50	PHYSICAL THERAPY			3,623			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS			306,490			
56	DRUGS CHARGED TO PATIENTS			2,305,624			
56	01 ONCOLOGY			124,822			
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY			1,486,689			
62	OBSERVATION BEDS (NON-DISTINCT PART)			178,954			
63	OTHER OUTPATIENT SERVICE COST CENTER						
63	50 RURAL HEALTH CLINIC						
101	SUBTOTAL			12,568,710			
102	CRNA CHARGES						
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES						
104	NET CHARGES			12,568,710			

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

PROVIDER NO:	PERIOD:	PREPARED 2/24/2010
14-1315	FROM 10/ 1/2008	WORKSHEET D
COMPONENT NO:	TO 9/30/2009	PART V
14-1315		

TITLE XVIII, PART B HOSPITAL

(A)		Cost Center Description	All Other 9	Hospital I/P Part B Charges 10	Hospital I/P Part B Costs 11
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	480,583		
40		ANESTHESIOLOGY	109,360		
41		RADIOLOGY-DIAGNOSTIC	866,428		
41	01	NUCLEAR MEDICINE-DIAGNOSTIC	152,052		
44		LABORATORY	525,961		
49		RESPIRATORY THERAPY	124,018		
49	01	SLEEP STUDIES	42,467		
50		PHYSICAL THERAPY	1,817		
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	119,299		
56		DRUGS CHARGED TO PATIENTS	1,152,980		
56	01	ONCOLOGY	119,182		
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	600,376		
62		OBSERVATION BEDS (NON-DISTINCT PART)	139,485		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC			
101		SUBTOTAL	4,434,008		
102		CRNA CHARGES			
103		LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104		NET CHARGES	4,434,008		

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

PROVIDER NO:	PERIOD:	PREPARED	2/24/2010
14-1315	FROM 10/ 1/2008	WORKSHEET D	
COMPONENT NO:	TO 9/30/2009	PART VI	
14-1315			

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

		1
1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	.500073
2	PROGRAM VACCINE CHARGES	4,143
3	PROGRAM COSTS	2,072

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	2,751
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,206
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,206
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	118
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	382
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	11
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	34
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,595
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	118
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	382
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	92.65
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	93.14
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,759,256
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,019
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	3,167
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	513,251
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,246,005
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,004,031
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,004,031
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.120744
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	908.45
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,246,005

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	1,018.13
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,623,917
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,623,917

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					

		1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	1,033,451
49	TOTAL PROGRAM INPATIENT COSTS	2,657,368
	PASS THROUGH COST ADJUSTMENTS	
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	
52	TOTAL PROGRAM EXCLUDABLE COST	
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	
	TARGET AMOUNT AND LIMIT COMPUTATION	
54	PROGRAM DISCHARGES	
55	TARGET AMOUNT PER DISCHARGE	
56	TARGET AMOUNT	
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	
58	BONUS PAYMENT	
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.	
58.04	RELIEF PAYMENT	
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)	
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1	
59.03	PROGRAM DISCHARGES AFTER JULY 1	
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)	
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)	
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	
	PROGRAM INPATIENT ROUTINE SWING BED COST	
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	120,139
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	388,926
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	509,065
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

TITLE XVIII PART A HOSPITAL OTHER

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	209
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,018.13
85	OBSERVATION BED COST	212,789

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(07/2009)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET D-4

I COMPONENT NO: 14-1315 I

TITLE XVIII, PART A HOSPITAL OTHER

LINE NO.	A	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
		INPAT ROUTINE SRVC CNTRS			
25		ADULTS & PEDIATRICS		1,584,700	
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	.440110	111,832	49,218
40		ANESTHESIOLOGY	1.768267	27,458	48,553
41		RADIOLOGY-DIAGNOSTIC	.234774	436,693	102,524
41	01	NUCLEAR MEDICINE-DIAGNOSTIC	.200477	11,537	2,313
44		LABORATORY	.270604	608,568	164,681
49		RESPIRATORY THERAPY	.275904	224,955	62,066
49	01	SLEEP STUDIES	.254871		
50		PHYSICAL THERAPY	.501580	94,746	47,523
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.389243	501,814	195,328
56		DRUGS CHARGED TO PATIENTS	.500073	722,109	361,107
56	01	ONCOLOGY	.954816	145	138
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	.403834		
62		OBSERVATION BEDS (NON-DISTINCT PART)	.779447		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC			
		OTHER REIMBURS COST CNTRS			
101		TOTAL		2,739,857	1,033,451
102		LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103		NET CHARGES		2,739,857	

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(07/2009)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET D-4

I COMPONENT NO: 14-Z315 I

TITLE XVIII, PART A SWING BED SNF OTHER

A NO.		COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
		INPAT ROUTINE SRVC CNTRS			
25		ADULTS & PEDIATRICS			
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	.440110		
40		ANESTHESIOLOGY	1.768267		
41		RADIOLOGY-DIAGNOSTIC	.234774	30,013	7,046
41	01	NUCLEAR MEDICINE-DIAGNOSTIC	.200477		
44		LABORATORY	.270604	54,086	14,636
49		RESPIRATORY THERAPY	.275904	31,262	8,625
49	01	SLEEP STUDIES	.254871		
50		PHYSICAL THERAPY	.501580	87,497	43,887
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.389243	97,248	37,853
56		DRUGS CHARGED TO PATIENTS	.500073	166,677	83,351
56	01	ONCOLOGY	.954816		
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	.403834		
62		OBSERVATION BEDS (NON-DISTINCT PART)	.779447		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC			
		OTHER REIMBURS COST CNTRS			
101		TOTAL		466,783	195,398
102		LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103		NET CHARGES		466,783	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 2/24/2010
14-1315	FROM 10/ 1/2008	WORKSHEET E
COMPONENT NO:	TO 9/30/2009	PART B
14-1315		

T B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,436,080
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	4,436,080
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	4,480,441
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	36,904
18.01	CAH ACTUAL BILLED COINSURANCE LINE 17.01 (SEE INSTRUCTIONS)	2,128,379
19	SUBTOTAL (SEE INSTRUCTIONS)	2,315,158
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	2,315,158
24	PRIMARY PAYER PAYMENTS	1,166
25	SUBTOTAL	2,313,992
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	367,398
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	367,398
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	356,883
28	SUBTOTAL	2,681,390
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	2,681,390
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	3,779,745
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-1,098,355
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	33,360
	TO BE COMPLETED BY CONTRACTOR	
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO:	I PERIOD:	I PREPARED	2/24/2010
I 14-1315	I FROM 10/ 1/2008	I WORKSHEET	E-1
I COMPONENT NO:	I TO 9/30/2009	I	
I 14-1315	I	I	

TITLE XVIII HOSPITAL

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			2,252,061		3,883,814
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01				
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50	4/24/2009	60,895	4/24/2009	104,069
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		-60,895		-104,069
4	TOTAL INTERIM PAYMENTS			2,191,166		3,779,745
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1) SETTLEMENT TO PROVIDER	.01		220,885		
	SETTLEMENT TO PROGRAM	.02				1,098,355
7	TOTAL MEDICARE PROGRAM LIABILITY			2,412,051		2,681,390

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96 (11/1998)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET E-1
I COMPONENT NO: 14-Z315 I

TITLE XVIII SWING BED SNF

DESCRIPTION			INPATIENT-PART A MM/DD/YYYY 1	AMOUNT 2	PART B MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				634,632		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.				NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)						
	ADJUSTMENTS TO PROVIDER	.01	4/24/2009	5,180		
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
SUBTOTAL		.99		5,180		NONE
4 TOTAL INTERIM PAYMENTS				639,812		
TO BE COMPLETED BY INTERMEDIARY						
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)						
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
SUBTOTAL		.99		NONE		NONE
DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER	.01		50,202		
	SETTLEMENT TO PROGRAM	.02				
7 TOTAL MEDICARE PROGRAM LIABILITY				690,014		

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

PROVIDER NO:	PERIOD:	PREPARED	2/24/2010
14-1315	FROM 10/ 1/2008		
COMPONENT NO:	TO 9/30/2009	WORKSHEET	E-2
14-Z315			

TITLE XVIII SWING BED SNF

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	514,156	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	197,352	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	500	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	711,508	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	711,508	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	711,508	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	21,494	
14	80% OF PART B COSTS		
15	SUBTOTAL	690,014	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	690,014	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	639,812	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	50,202	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	5,309	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 2/24/2010
14-1315	FROM 10/ 1/2008	WORKSHEET E-3
COMPONENT NO:	TO 9/30/2009	PART II
14-1315		

II - MEDICARE PART A SERVICES - COST REIMBURSEMENT
HOSPITAL

1	INPATIENT SERVICES	2,657,368
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,657,368
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,683,942
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	2,683,942
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	305,660
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,378,282
23	COINSURANCE	
24	SUBTOTAL	2,378,282
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	33,769
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	33,769
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	31,089
26	SUBTOTAL	2,412,051
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	2,412,051
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	2,191,166
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	220,885
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	20,015

Health Financial Systems MCRIF32 FOR BCC DBA ILLINI COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96 (06/2003)

BALANCE SHEET | PROVIDER NO: 14-1315 | PERIOD: FROM 10/ 1/2008 TO 9/30/2009 | PREPARED 2/24/2010 | WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	2,589,148			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	7,852,945			
5	OTHER RECEIVABLES	-1,258,879			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-4,630,362			
7	INVENTORY	441,501			
8	PREPAID EXPENSES	175,988			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	5,170,341			
	FIXED ASSETS				
12	LAND	134,251			
12.01					
13	LAND IMPROVEMENTS	221,456			
13.01	LESS ACCUMULATED DEPRECIATION	-134,266			
14	BUILDINGS	7,289,739			
14.01	LESS ACCUMULATED DEPRECIATION	-2,202,871			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	4,875,439			
18.01	LESS ACCUMULATED DEPRECIATION	-3,728,339			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	6,455,409			
	OTHER ASSETS				
22	INVESTMENTS	9,162			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	250			
26	TOTAL OTHER ASSETS	9,412			
27	TOTAL ASSETS	11,635,162			

	LIABILITIES AND FUND BALANCE	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	342,196			
29	SALARIES, WAGES & FEES PAYABLE	576,235			
30	PAYROLL TAXES PAYABLE	31,053			
31	NOTES AND LOANS PAYABLE (SHORT TERM)				
32	DEFERRED INCOME				
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS	952,125			
35	OTHER CURRENT LIABILITIES	528,967			
36	TOTAL CURRENT LIABILITIES	2,430,576			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE	5,386,720			
38	NOTES PAYABLE				
39	UNSECURED LOANS				
40.01	LOANS PRIOR TO 7/1/66				
40.02	ON OR AFTER 7/1/66				
41	OTHER LONG TERM LIABILITIES	138,943			
42	TOTAL LONG-TERM LIABILITIES	5,525,663			
43	TOTAL LIABILITIES	7,956,239			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	3,678,923			
45	SPECIFIC PURPOSE FUND				
46	DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47	DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48	GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49	PLANT FUND BALANCE-INVESTED IN PLANT				
50	PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51	TOTAL FUND BALANCES	3,678,923			
52	TOTAL LIABILITIES AND FUND BALANCES	11,635,162			

STATEMENT OF CHANGES IN FUND BALANCES

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET G-1

		GENERAL FUND 1	GENERAL FUND 2	SPECIFIC PURPOSE FUND 3	SPECIFIC PURPOSE FUND 4
1	FUND BALANCE AT BEGINNING OF PERIOD		2,529,485		
2	NET INCOME (LOSS)		1,009,214		
3	TOTAL		3,538,699		
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	RELEASED FROM RESTRICTION	105,084			
5	CONTRIBUTIONS	230,450			
6					
7					
8					
9					
10	TOTAL ADDITIONS		335,534		
11	SUBTOTAL		3,874,233		
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	RELEASED FROM RESTRICTION	195,310			
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS		195,310		
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		3,678,923		

		ENDOWMENT FUND 5	ENDOWMENT FUND 6	PLANT FUND 7	PLANT FUND 8
1	FUND BALANCE AT BEGINNING OF PERIOD				
2	NET INCOME (LOSS)				
3	TOTAL				
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	RELEASED FROM RESTRICTION				
5	CONTRIBUTIONS				
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL				
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	RELEASED FROM RESTRICTION				
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET				

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | PROVIDER NO: 14-1315 | PERIOD: FROM 10/ 1/2008 TO 9/30/2009 | PREPARED 2/24/2010 | WORKSHEET G-2 | PARTS I & II

PART I - PATIENT REVENUES

		REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
		GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00	HOSPITAL	2,004,031		2,004,031
4	00	SWING BED - SNF	257,131		257,131
5	00	SWING BED - NF	23,142		23,142
9	00	TOTAL GENERAL INPATIENT ROUTINE CARE	2,284,304		2,284,304
		INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15	00	TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16	00	TOTAL INPATIENT ROUTINE CARE SERVICE	2,284,304		2,284,304
17	00	ANCILLARY SERVICES	4,245,080	31,856,437	36,101,517
18	00	OUTPATIENT SERVICES			
18	50	RURAL HEALTH CLINIC		1,030,066	1,030,066
24	00				
25	00	TOTAL PATIENT REVENUES	6,529,384	32,886,503	39,415,887

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES		17,424,135
		ADD (SPECIFY)		
27	00	PROVISION FOR BAD DEBTS	1,310,094	
28	00			
29	00			
30	00			
31	00			
32	00			
33	00	TOTAL ADDITIONS		1,310,094
		DEDUCT (SPECIFY)		
34	00	DEDUCT (SPECIFY)		
35	00			
36	00			
37	00			
38	00			
39	00	TOTAL DEDUCTIONS		
40	00	TOTAL OPERATING EXPENSES		18,734,229

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET G-3

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	39,415,887
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	20,078,410
3	NET PATIENT REVENUES	19,337,477
4	LESS: TOTAL OPERATING EXPENSES	18,734,229
5	NET INCOME FROM SERVICE TO PATIENTS	603,248
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	102,145
7	INCOME FROM INVESTMENTS	25,394
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	53,768
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS,FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	123,475
23	GOVERNMENTAL APPROPRIATIONS	
24	MISCELLAENOUS INCOME	101,184
25	TOTAL OTHER INCOME	405,966
26	TOTAL	1,009,214
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	1,009,214

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: 14-1315 I COMPONENT NO: 14-3482
I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009
I PREPARED 2/24/2010 I WORKSHEET M-1

RHC 1

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFICATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN				
2	PHYSICIAN ASSISTANT				
3	NURSE PRACTITIONER	56,902		56,902	
4	VISITING NURSE				
5	OTHER NURSE	93,183		93,183	15,094
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN				
9	OTHER FACILITY HEALTH CARE STAFF COSTS				
10	SUBTOTAL (SUM OF LINES 1-9)	150,085		150,085	15,094
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT		432,751	432,751	
12	PHYSICIAN SUPERVISION UNDER AGREEMENT		184	184	-184
13	OTHER COSTS UNDER AGREEMENT		121,980	121,980	
14	SUBTOTAL (SUM OF LINES 11-13)		554,915	554,915	-184
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES				
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS		11,375	11,375	
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)		11,375	11,375	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	150,085	566,290	716,375	14,910
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY				
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS				
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
	FACILITY OVERHEAD				
29	FACILITY COSTS		32,052	32,052	
30	ADMINISTRATIVE COSTS	98,647	35,559	134,206	
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	98,647	67,611	166,258	
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	248,732	633,901	882,633	14,910

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER NO:	PERIOD:	PREPARED
14-1315	FROM 10/ 1/2008	WORKSHEET M-1
COMPONENT NO:	TO 9/30/2009	
14-3482		

RHC 1

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN			
2	PHYSICIAN ASSISTANT			
3	NURSE PRACTITIONER	56,902		56,902
4	VISITING NURSE			
5	OTHER NURSE	108,277		108,277
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS			
10	SUBTOTAL (SUM OF LINES 1-9)	165,179		165,179
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT	432,751	-51,375	381,376
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT	121,980		121,980
14	SUBTOTAL (SUM OF LINES 11-13)	554,731	-51,375	503,356
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES			
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS	11,375		11,375
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)	11,375		11,375
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	731,285	-51,375	679,910
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS	32,052	-5,591	26,461
30	ADMINISTRATIVE COSTS	134,206		134,206
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	166,258	-5,591	160,667
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	897,543	-56,966	840,577

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED 2/24/2010
14-1315	FROM 10/ 1/2008	WORKSHEET M-2
COMPONENT NO:	TO 9/30/2009	
14-3482		

RHC 1

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS	1.81	5,592	4,200	7,602
2	PHYSICIAN ASSISTANTS			2,100	
3	NURSE PRACTITIONERS	.67	2,061	2,100	1,407
4	SUBTOTAL (SUM OF LINES 1-3)	2.48	7,653		9,009
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2.48	7,653		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				

	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES	
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	679,910
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	679,910
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	160,667
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	314,419
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	475,086
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)	
18	SUBTRACT LINE 17 FROM LINE 16	475,086
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	475,086
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,154,996

		GREATER OF COL. 2 OR COL. 4 5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	9,009
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	9,009
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

(1) THE PRODUCTIVITY STANDARD FOR PHYSICIANS IS 4,200 AND 2,100 FOR ALL OTHERS. IF AN EXCEPTION TO THE STANDARD HAS BEEN GRANTED (WORKSHEET S-8, LINE 13 EQUALS "Y"), COLUMN 3, LINES 1 THRU 3 OF THIS WORKSHEET SHOULD BE BLANK. THIS APPLIES TO RHC ONLY.

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED
14-1315	FROM 10/ 1/2008	WORKSHEET M-3
COMPONENT NO:	TO 9/30/2009	
14-3482		

TITLE XVIII RHC 1

	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	1,154,996
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	4,246
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,150,750
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	9,009
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	9,009
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	127.73

		CALCULATION OF LIMIT (1)	
		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	75.63	76.84
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	127.73	127.73
	CALCULATION OF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	418	1,280
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	53,391	163,494
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		216,885
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		14,098
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		202,787
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		162,230
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		1,716
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		163,946
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		163,946
25	INTERIM PAYMENTS		150,353
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		13,593
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		1,305

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDER YEAR PROVIDERS USE COLUMN 2 ONLY.

* FOR LINE 15, USE COLUMN 2 ONLY FOR GRADUATE MEDICAL EDUCATION PASS THROUGH COST.

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

PROVIDER NO:	PERIOD:	PREPARED
14-1315	FROM 10/ 1/2008	WORKSHEET M-4
COMPONENT NO:	TO 9/30/2009	
14-3482		

TITLE XVIII RHC 1

		PNEUMOCOCCAL 1	INFLUENZA 2
1	HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	165,179	165,179
2	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000035	.002480
3	PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	6	410
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	105	1,979
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	111	2,389
6	TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	679,910	679,910
7	TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	475,086	475,086
8	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.000163	.003514
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	77	1,669
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	188	4,058
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	3	215
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	62.67	18.87
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	3	81
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	188	1,528
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		4,246
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		1,716

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES
[X] RHC [ ] FQHC

I PROVIDER NO: 14-1315 I PERIOD: I FROM 10/ 1/2008 I TO 9/30/2009 I PREPARED 2/24/2010 I WORKSHEET M-5
I COMPONENT NO: 14-3482 I

RHC 1

	DESCRIPTION		PART B MM/DD/YYYY 1	AMOUNT 2
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			150,353
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	ADJUSTMENTS TO PROVIDER	.01		
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50		
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	SUBTOTAL	.99		NONE
4	TOTAL INTERIM PAYMENTS			150,353
	TO BE COMPLETED BY INTERMEDIARY			
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	TENTATIVE TO PROVIDER	.01		
	TENTATIVE TO PROVIDER	.02		
	TENTATIVE TO PROVIDER	.03		
	TENTATIVE TO PROGRAM	.50		
	TENTATIVE TO PROGRAM	.51		
	TENTATIVE TO PROGRAM	.52		
	SUBTOTAL	.99		NONE
	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02		13,593
7	TOTAL MEDICARE PROGRAM LIABILITY			163,946

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.